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September 21, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

ATTENTION: OCIIO-9993-IFC

RE: Internal Claims and Appeals and External Review Processes

Dear Secretary Sebelius:

WellPoint Inc. (WellPoint) appreciates the opportunity to respond to the "Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act" published July 23, 2010. We look forward to working with the Departments of Health and Human Services (HHS), Labor (DOL) and Treasury (Treasury) to successfully implement these reforms.

WellPoint is the largest publicly traded commercial health benefits company in terms of membership in the United States with 33.8 million medical members at March 31, 2010, and 1.1 million Medicare enrollees. WellPoint is an independent licensee of the Blue Cross Blue Shield Association and serves its members as the Blue Cross licensee for California; the Blue Cross and Blue Shield licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as Blue Cross Blue Shield in 10 New York City metropolitan counties and as Blue Cross or Blue Cross Blue Shield in selected upstate counties only), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.), and Wisconsin; and UniCare Life and Health nationwide.

Overview

WellPoint supports the rights of members to appeal and request external review of adverse benefit determinations, and appreciates that the ACA provisions sought to make these rights uniform across all individuals and plans. However, we are concerned that this interim final rule (IFR) will have the unintended effect of creating different standards for different markets.

In general, WellPoint is concerned about the extent to which this IFR broadens the scope of internal appeals and external review. The external review requirements go well beyond the practices currently in place in states and exceed the NAIC Uniform Model Act guidelines, which are referenced in the rule as a standard for compliant states. Further, the rule appears to extend internal appeals and external reviews to nearly every decision that a plan makes, without any parameters to ensure that these rights are exercised reasonably. For example, an individual who is denied initial enrollment in a plan because she resides outside of the plan's service area should not be permitted to appeal or request external review of that decision.

We believe that it was not the Departments' intention to broaden the scope as far beyond current practice, and the NAIC guidelines, as the IFR appears to do. We encourage the Departments to rely on the NAIC guidelines as the model for the state and federal external review processes, and to implement reasonable limits on the basis for which members may access the internal appeals process.

These recommendations and others are further reflected in our comments below.

Expedited Notification of Benefit Determinations Involving Urgent Care

The IFR reduces the time allotted for review and notification of benefit determinations involving urgent care from 72 hours to 24 hours. While WellPoint is already committed to making urgent determinations as expeditiously as possible, our efforts are frequently constrained by external factors such as waiting for providers to submit additional information that is needed to make a fully informed determination.

The new 24-hour standard raises several concerns. This change will newly require plan and provider staff to be available over the weekend and during other non-business hours. WellPoint does not currently employ staff to make determinations over the weekend, nor do most physician offices. However, we could, albeit at some administrative and operational expense, make the necessary changes to comply. More importantly, we are concerned about providers' ability to make similar changes to be available for consultation or to submit needed records or additional information.

WellPoint believes it is beneficial for members to conduct a high quality, comprehensive review of the request and to make a fully informed determination, which may mean pending the decision until we have all needed information. Under the new 24-hour requirement, we are concerned that we may not be able to gather the necessary information to conduct a thorough review. While we can redeploy our own resources to make an urgent determination within 24 hours, we are only one part of the process. We rely on providers to share needed information, much of which is not available electronically. Providers may simply not have the staff or other resources in place to turn around a request that quickly.

WellPoint currently follows the standards set by accreditation organizations such as NCQA and URAC for review of urgent claims. We believe that their 72-hour standard recognizes the multiple parties involved in the process and balances the need to ensure a thorough, high quality review against the urgency of the request. We urge the Departments to reconsider their proposal to deviate from this existing and reasonable requirement with which plans already comply.

Full and Fair Review of Claims

The IFR requires that the plan or issuer must permit the claimant to review the claim file, provide the claimant with any new evidence, and permit the claimant to present evidence and testimony. WellPoint urges the Departments to consider the careful balance between these requirements and plans' and claimants' desires that a determination of benefits be made as expeditiously as possible. Requiring plans to automatically provide information to claimants will lengthen plans' timeframes for making benefit determinations. We believe that it should be up to members to exercise this option; in many instances, we believe that members would prefer to forgo receipt of evidence in favor of a faster determination. Thus, WellPoint recommends that the Departments modify the provision to require that plans and issuers make evidence and other information available upon request by the claimant rather than automatically for all claimants. Further, because the evidence is likely to include protected health information (PHI), sending the information only at the request of the member will limit the release of PHI and the potential for inadvertent receipt by an unintended party.

Notices

Plans and issuers must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes sufficient information to identify the claim involved, including the diagnosis and procedure codes and their corresponding meanings. WellPoint agrees that the notices should be clear and understandable to the individual, but we have concerns about the requirement to include detailed clinical information such as diagnosis and procedure codes.

Our primary concern is for patients' privacy. Communication from plans, such as explanations of benefits (EOBs) and notices about appeals rights and determinations, are sent to the policy holder. The policy holder is not always the patient who received or requested to receive the services described in the notice. Including detailed information, such as diagnosis and procedure codes and their detailed descriptions would, in effect, result in the transmission of sensitive patient information to another individual. An example from our own experience is when a husband contacted WellPoint to obtain the diagnosis for a procedure included on an EOB for his wife. In this case, the wife had an abortion that she had not disclosed to her husband. In our verbal communication with the husband, we were able to protect his wife's privacy. We would not be able to do so, however, if required to report detailed diagnosis and procedure information on plan notices. Similarly sensitive symptoms, such as those pertaining to behavioral health conditions or diagnoses such as AIDS, would also be at risk of inadvertent and inappropriate disclosure to parties other than the patient if diagnosis codes were required to be included on plan notices. Even in cases where plan notices are addressed to the patient, the risk for inappropriate disclosure of sensitive information would be heightened if plans are required to routinely include detailed codes and descriptions. For example, consider a scenario where another member of a household opens a notice from the plan either intentionally or inadvertently, or instances when the notice is delivered to the wrong address.

Additionally, WellPoint does not want to interfere in the doctor-patient relationship. In a typical doctor-patient interaction, the physician informs the patient of his condition or illness and instructs him on the appropriate course of treatment. Rarely, if ever, would the physician tell the patient the diagnosis and procedure codes billed for the visit. As a plan, we do not believe it is our role to provide clinical information to the patient that the physician himself did not convey. Doing so could create confusion and anxiety for patients. For example, a claim may be coded with a diagnosis of cancer or AIDS because a test was conducted to rule out the condition. In

such cases, the patient may not have known that the condition was being ruled out, or the provider may not have had a chance to convey the results to the patient prior to receipt of the plan communication. In either case the patient would be alarmed, without having complete information. We would prefer to leave these communications to the doctor and patient, without interference by the plan.

For these reasons, WellPoint instituted a set of changes to our EOBs and other plan communications several years ago. These changes aimed to increase their clarity and improve safeguards of members' privacy. Among these changes, we removed diagnosis and procedure codes and used simpler language to explain the service delivered. For example, the EOB distinguishes if the service was an office visit or lab test, but does not indicate the associated condition or diagnosis. Our experience indicates that the vast majority of members would not get additional value from diagnosis or procedure codes. Therefore, in light of the significant privacy concerns which we believe far outweigh any benefit, we recommend that the Departments exclude the requirement that diagnosis and procedure codes and descriptions be included in appeals and review notices.

Minimum Standards for State External Review Processes

The IFR specifies that a compliant state external review process must provide for external review of adverse benefit determinations that are based on "medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit." This requirement is broader than the scope of current state processes, as well as that of the NAIC Uniform Model Act, which is generally referenced as the standard for an accepted state external review process. WellPoint respectfully requests that the Departments provide clarification that the federal process mirrors the state process, which should, in turn, follow the NAIC model.

Further, WellPoint recommends that the Departments limit the scope of state external review processes to the customary bases for review: medical necessity, appropriateness, health care setting, and level of care. Should the Departments wish to maintain inclusion of "effectiveness of covered benefits," among the bases for review, we recommend that the Departments revise the language to be "effectiveness of the health care service or treatment" as in the NAIC Model Act.

Provision of Notices in a Culturally and Linguistically Appropriate Manner

The regulation specifies that group health plans with fewer than 100 participants must provide notices in any non-English language in which at least 25 percent of enrollees are only literate. Plans with 100 or more participants must do so for any non-English language in which the lesser of 10 percent or 500 participants are only literate. Additionally, plans must include a statement in the non-English language on English language notices and automatically provide subsequent notices in the non-English language.

WellPoint applauds the Departments' efforts to provide member notices in a culturally and linguistically appropriate manner. However, we are concerned that the proposed approach for group plans will be difficult and impractical to implement. In many cases, we may not be aware of, or able to determine, the language spoken by each member of a group plan in order to evaluate whether non-English notices are required. Furthermore, setting the threshold by plan, rather than community, could result in an overwhelming burden for plans. For example, if a small group plan has only four members and one speaks an uncommon English language, the plan would have to generate notices in that language and add the statement on all English

notices for the benefit of a single member. If this scenario were repeated across many small group plans, the administrative expense and complexity would be multiplied. Further, we are concerned by the short time frame in which we have to implement these new requirements. It took more than a year to implement California's limited English proficiency requirements, as multiple systems and processes are implicated, and it is important to take the time to ensure that translated documents are accurate.

As we do today, WellPoint would like to continue offering notices based upon the linguistic needs of the community, rather making a determination separately for each plan's participants. The IFR and subsequent technical guidance requires that individual health plans determine on a county-by-county basis whether, and which, non-English language notices must be provided. WellPoint recommends that the determination be made at the state level, and that it be used for both individual and group health plans. Additionally, we respectfully request that the Departments use a standard methodology in all rulemaking related to the Affordable Care Act for determining when non-English language notices and language assistance be given. It would be inefficient and significantly complex to require different thresholds for different notices or aspects of a plan's business.

Also, the technical guidance released for issuers in the individual market directs plans to use Census data to determine in which non-English languages they must provide notices. The data does not clearly specify the language in many instances. For example, one category is "Other Indo-European languages." In those cases in which the data indicates a category of languages rather than a specific language, we suggest that an issuer be permitted to demonstrate compliance by either providing notices in the most common language in the category for the state or surveying its membership in the state to determine which specific languages within the category meet the threshold requirements.

Finally, given past experience, WellPoint recommends that non-English notices be provided to members only upon request. We want to ensure that we do not offend members by providing non-English notices automatically.

Technical Release for Federal External Review

On August 23, 2010, the Department of Labor released additional guidance on the federal external review process for self-insured group health plans. The guidance offers plans two options for complying with external review requirements: compliance with a state process or compliance with the federal process. However, this is not a meaningful choice as plans cannot comply with the state process unless the state acts first to extend the process to self-insured plans. Most state legislatures will not convene again until early 2011, which will not be soon enough for plans to comply with the guidance. Further, even if states could act sooner, they may be reluctant to do so given current budget constraints. WellPoint recommends that the Department instead permit plans to follow the state process without actually using the state resources. That is, the plan would operationalize the state process on its own; this would not require state approval.

The technical guidance also requires that plans utilize Independent Review Organizations (IROs) in the external review process. We request that the Department clarify that third party administrators (TPAs) are permitted to contract with IROs for this purpose on behalf of the self-insured group plan. The guidance appears to imply that group health plans must contract with IROs themselves, but we do not believe this was the Department's intent.

In addition, the guidance requires that IROs assume responsibility for issuing notices and letters throughout the appeals process rather than allowing health plans or issuers to do so. Today, no IRO is responsible for communicating with claimants, and is unlikely to have all of the needed information required for the notices, which the plan does have. Therefore, WellPoint recommends that the Department permit plans to provide notices, with appropriate regulation or oversight.

Model Notices

The Departments also released three model notices for Adverse Benefit Determinations, Final Internal Adverse Benefit Determinations, and Final External Review Decisions. WellPoint does not have the ability to begin using these model notices on September 23, 2010. First, we estimate that programming these notices into our system could take up to six months. Furthermore, the programmers who would be tasked with adding these model notices to the systems are currently implementing the transition to ICD-10 and the upgrade to the 5010 version of the HIPAA transactions. Second, before we can use these model notices, we must file them for review by state regulators. States have both their own filing deadlines and timelines, as well as their own requirements for such notices. For these reasons, we believe twelve months would be a more reasonable timeframe to implement the model notices effectively.

Finally, we are also concerned that the model notices require information that may not be applicable or available. For instance, amount paid would not apply for a pre-service appeal. We request that the Departments clarify that non-applicable fields could be omitted.

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WellPoint appreciates this opportunity to offer our suggestions for implementation of the internal appeals and external review regulations. Should you have any questions or wish to discuss our comments further, please contact Jennifer Boyer at 202-628-7831 or Jennifer.Boyer@WellPoint.com.

Sincerely,

Elizabeth P. Hall
Vice President, Public Policy